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ABSTRACT

Brief therapy is an effective, time-limited approach that invokes clients values, appreciates their strengths, and is based on mutual respect. Counseling nonvoluntary clients can be extremely difficult because of the intense degree of denial, minimization, or rationalization of problems such clients typically bring to therapy. Therapists must overcome the challenge of working constructively with a client who does not acknowledge his or her problems and must find the will to treat the client with a modicum of impartiality. Brief counseling is arguably the best match for difficult clients--not only because health care plans continue to stress the need for short-term mental health care interventions, but also because these clients are not willing to participate in the counseling process. In this lesson practical strategies for working briefly with difficult clients are offered. Building cooperation, defusing dismal experiences with previous therapy, avoiding arguments, solidifying gains, and establishing a support network are especially important for successful therapy with this client population. By focusing on tangible behaviors and normalizing those which might otherwise contribute to isolation, a brief strategic approach to counseling and resolving problems lends itself well to clinical work with difficult clients. (JBJ)

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Brief Therapy with Difficult Clients

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Editor's Note

Counseling nonvoluntary clients can be extremely difficult because of the intense degree of denial, minimization, or rationalization of problems such clients typically bring to therapy. The therapists must overcome the intimidating challenge of working constructively with a client who does not acknowledge his or her problems. The therapist also must find the will to treat, for example, a nonvoluntary client (e.g., a partner accused of domestic violence; a school-referred adolescent exhibiting behavior trouble in the classroom; an alcoholic whose spouse has threatened divorce unless he or she seeks counseling) with a modicum of impartiality. Brief therapy is arguably the best therapeutic match for difficult clients—not only because health care plans continue to stress the need for short-term mental health care interventions, but also because these clients (at least initially) are not willing participants in the counseling process. Informing difficult clients of the rationale for using brief therapy—to serve their interests swiftly—may be the key to facilitating compliance with requests for information and suggestions for change.

As with any client, the first interview sets the stage for establishing the therapeutic alliance. With a difficult client, the mental health professional must focus on building cooperation *without* projecting an overly authoritative stance or subtly condoning the client's abusive or antisocial behavior. The therapist also must monitor their responses to the client's resistance. A contentious tone will only exacerbate an already tense situation. Instead, initial resistance should be viewed as reasonable caution, a positive sign of strength. It is the therapist's task to work cooperatively with the resistant client to accomplish something the client considers of benefit.

In this lesson, the author offers many practical strategies for working briefly with difficult clients. Building cooperation, defusing dismal experiences with previous therapy, avoiding arguments, solidifying gains, and establishing a support network are especially important for successful therapy with this client population. By focusing on tangible behaviors and normalizing those which might otherwise contribute to isolation, a brief strategic approach to counseling and resolving problems lends itself well to clinical work with difficult clients.

Introduction

In an ideal world, any person with a significant problem would voluntarily seek the services of a mental health professional and say, "I have a problem that I am unable to resolve on my own, so I have come to ask your help." Such persons would be compliant with requests for information and suggestions about changes, and there would be ample time available for clinicians to work with them. **However, with nonvoluntary clients, people with multiple problems, or other difficult clients, the situation is, unfortunately, very different—in fact almost the opposite in every major respect**. The therapist seeing clients who are participating in the process under duress must essentially declare, "You have a problem." **Especially in cases of violence and abuse, clients usually prefer to deny, minimize, or rationalize their problems.** This start initially will likely be interpreted as blame and accusation. Although the therapist has considerable formal authority over court-ordered clients, especially involving consequences that can be threatened or imposed, **this authoritative stance will likely be interpreted as an accusation and will elicit defensive reactions, withdrawal, or passive resistance rather than cooperation**.

This lesson will provide the theoretical basis and several practical guidelines for working briefly with difficult clients. **The main therapeutic challenge is to establish rapport and assist clients in making small but significant changes that will improve immediate functioning and possibly promote continued improvement**.

Definitions and Principles

Therapy is defined as the **process of assisting another (or others) in developing mastery and empathy, as well as in restoring growth and development**. *Brief therapy* is an effective, time-limited approach that **invokes clients' values, appreciates their strengths, and is based on mutual respect**. The objective for the therapist who employs a brief strategic approach to counseling is to **recommend *small* changes that improve the presenting problem and, potentially, introduce more systemic change**.

Difficult clients are persons **burdened by multiple problems and poor past experiences with helpers** (medical or mental health providers, social service agents, educators) from whom they do not seek help voluntarily. **Another party—a court, supervisor, spouse, or parent—compels them to undergo treatment**. Voluntary clients often enter therapy because they feel depleted of energy and options, having tried everything else to no avail. **Difficult clients, on the other hand, may feel more energetic and more able to manage on their own. They are more straightforward about their disinclination to undergo therapy.** The therapist should understand that without a prior worthwhile experience with therapy, a person cannot know its possible benefits. **Initial resistance should be viewed as a positive sign of strength and personal boundaries. Motivation will develop as clients see the benefit of meeting with the therapist**, and is thus more properly viewed as an outcome measure of the usefulness of treatment.

The customary principles of *trust* and *confidentiality* apply more to voluntary clients. Difficult clients will not trust readily, nor is trust a reasonable expectation of them. Rather, **the therapist should aim to demonstrate his or her credibility and reliability,** and should avoid triggering the client's mistrust. The use of mandatory reporting laws is one good example of this principle. **Clarifying limits of confidentiality at the outset of treatment minimizes the client's surprise when a report must be made. Unless the therapist fears for his or her physical safety, the report should be made in the presence of the client to avoid triggering mistrust, anger, and speculation.** Preparing the report in a timely and responsible manner demonstrates the therapist's credibility, reliability, and forthrightness. **The report should begin with a summary of the client's**

strengths and progress in treatment, followed by a description of the danger or abuse and the therapist's willingness to continue working with the client. In addition, the therapist should give the client the opportunity to speak with the authority. In doing so, the therapist models responsible behavior and the ability to deal with difficult situations.

In brief treatment with difficult clients, the therapist must demonstrate the usefulness of the sessions by respectful, active intervention. **The artificiality of the relationship is a given, not limited by idealistic notions of trust and confidentiality;** however, by being predictable and reliable, the therapist honors boundaries and limits. Through constructive, practical suggestions, jointly created and consistent with the client's world view and values, incremental change can begin during the first session. Setting a positive example from the start enables the client to experience the potential value of therapy and become increasingly motivated as the work continues.

Theoretical Orientation

Regardless of a practitioner's theoretical persuasion, effective therapy has **two essential ingredients: mastery and empathy**. Sometimes called **transference** (in traditional psychoanalytic practice), **corrective emotional experience** (Alexander & French, 1946), or **second-order change** (Watzlawick, Weakland, & Fisch, 1974), **such interventions result both in self-control or mastery of something previously thought to exceed a person's grasp and in a sense of relatedness or concern for others**. A person who has self-control without concern for others has the ability to prevent recurrence of socially inappropriate behaviors, but not the motivation for consistent and significant change. **The converse of this is equally problematic. Acquiring an understanding of the deleterious effects of one's harmful behavior without also learning alternative responses would likely lead to despair, self-loathing, and relapse. Empathy provides the motivation to see the impact one has on others; mastery is the skill with which one can implement the desired behavior.**

In addition, because preoccupation with a problem may reduce the energy available for growth, it is often useful for the therapist to encourage advancement to the next stage of life (Haley, 1973). Forward-looking intervention is benign, requires no admission of failure by clients, allows problems and dysfunctional behaviors to be outgrown, and redirects attention to healthy maturation, of which the therapeutic change is one part. Particularly in work with children, who ideally progress rapidly from one developmental stage to the next and are usually eager to mature, such a developmental boost typically is welcomed by both the children and their family members. **Presenting the problematic behaviors as vestiges of a younger age that are now ready to be outgrown alleviates feelings of shame and promotes both normal growth and development.** Dr. Milton Erickson (Haley, 1973) suggested that clients and their families tend to seek the help of therapists when they are unable to meet the challenges of a new developmental stage and become stuck or symptomatic. "While focusing sharply on symptoms, Erickson's therapeutic strategy has as its larger goal the resolution of the problems of the family to get the life cycle moving again."

Building Cooperation

It is essential to clarify at the outset that promoting cooperation should in no way condone abusive or antisocial behavior; rather, it represents the most certain way to lead clients away from behavioral dysfunction, making it immediately safer for all those involved. To be sure, a cooperative and pleasant interview likely will leave clients in better spirits than will a contentious one. Therefore, **clients may be less prone to blame others for their problems or their need to undergo therapy**. Also, if they are able to work cooperatively with the therapist, they may become more resolved to attempt to manage their problems differently and feel more adequate in

general. At the very least, they will have experienced a more positive way of approaching difficult situations.

Initially, many clients are angry, defensive, or humiliated by having to meet with a therapist to address their handling of problems; legitimately, they may object to this type of intrusion into their private lives. It is crucial that counselors and clients form a partnership at the outset, lest limited energy and attention spans expire before the essential matters are addressed.

> *A 6-year-old boy was interviewed at his school after a referral was made describing his poor hygiene, dirty clothes, and combative behavior with his peers. Midway through the interview, the boy looked intently at the top of the counselor's head and exclaimed, "You have gray hair, you must be very old." Meeting his parents later that day, the counselor began by stating enthusiastically that they had the most delightful child and repeated his remark. The parents were so embarrassed at their child's lack of tact that they were congenial and cooperative throughout the interview. The parents agreed that the child's appearance attracted a lot of negative attention from both peers and teachers, preventing others from enjoying this obviously bright and witty child. The interview concluded with the parents thanking the counselor for her interest in the child and with the mutual goodwill that comes with shared laughter.*

Defusing Prior Failed Therapy

If clients have had prior experience with "the system," they may begin the first session with complaints and invective. The therapist should permit clients to state their prior objections, although **not endlessly,** for the following reasons:

- **Clients will not listen to or focus on anything else until they have stated their objections**;
- **Complaints about past approaches should help therapists avoid potential pitfalls in the current therapy**;
- It will provide a picture of **the client's outlook** and **indicate his or her emotional control**;
- Any tirade volunteered can be used to **gauge the amount of responsibility taken by clients, the efficacy of efforts made previously, and especially the values of clients and their perspective on the problem**.

Without defending or discrediting the other professionals mentioned by the client, the therapist can say it is understandable if the client felt mistreated by what happened (using his or her wording) and can voice regret that things had not gone better. The therapist can then express a desire to do better and be more considerate, as well as ask the client to point out immediately when the therapist errs. This unites the therapist and client in a common purpose, empowering clients by giving them an evaluative role.

Avoiding Arguments

Although it is not too difficult to avoid obvious and overt arguing, **arguing may occur in more subtle forms that are often unrecognized, especially when labeled otherwise—such as pointing out facts or clarifying realities or reasoning**. However, if clients do not readily respond to the opinion of their therapist, **repeated presentation of this view—no matter how justified by reason or evidence—constitutes arguing**. This jeopardizes rapport and hardens, rather than changes, the clients' position.

Steps for avoiding arguments include: listening attentively, even to provocative and apparently misguided clients; agreeing with clients as much as possible, even if the agreement must be subtly qualified ("From what you say, it certainly sounds as if...."); **finding ways to praise or approve of anything clients say that sounds positive**; and **framing any comments, reservations, or advice in terms that are consonant with the client's own language and expressed views**. Advice should be presented positively—neither resembling a put-down nor involving any loss of face.

A recently divorced couple was referred for therapy on the grounds of possible alcoholism and inappropriate sexual behavior by the father. As it turned out, the parents were devout Mormons throughout their marriage. The mother and children remained active in their faith after the father left the home, but he withdrew from the church. He was not drinking excessively, only approximately two drinks per week, but this was indeed a taboo for the rest of the family. He was unwilling to yield this practice to placate his ex-wife. However, when the therapist talked to him about his children's need for stability and continuity, and their inability to handle so many changes so quickly, he agreed, for their sakes, not to drink when they visited him.

Adapting the MRI Model

As pioneers in brief strategic therapy, the Mental Research Institute [MRI] team developed an approach to the solution of problems (Watzlawick, 1978; Watzlawick, Weakland, & Fisch, 1974). **The aim is to arrive at a clear, specific statement of the problem that reframes negative formulations positively and anticipates mastery of the problem.** The efforts already made by clients in unsuccessful attempts to solve the problem (called "attempted solutions" by the MRI team) should be examined to avoid repeating fruitless activities. A clear, specific, practical solution should be developed so success will be recognized when reached. **The intervention should be crafted in small, manageable steps that lead to the envisioned solution**. Table 1 presents an adaptation of the MRI model for counseling difficult clients.

A counselor met with the parents of a 13-year-old boy after his school nurse found more than 20 bruises on his back and buttocks. The child had told her that he had stopped to play a video game on his way home from an errand, spent 75¢ without permission, and then lied about it, thereby infuriating his parents. During her initial meeting with the parents, the counselor learned that the mother, a waitress, came home from work each day and put all her change from tips in a jar. She suspected that her son stole quarters from this jar. The boy also lied about his homework and was failing math. The parents described the child as a thief and a liar and asked questions about "tough love," the possibility of sending the child to jail for a weekend, and other severe measures to show the child the logical extreme of his misbehavior.

The counselor began by stating that she saw how much they cared about the child's future and how worried they were; they agreed. Her aim was to convey appreciation of their concern while also introducing the idea that they had a rather nice son who happened to have a video-game habit and the erratic impulse control typical of children his age. She volunteered that if she were left alone in a room with a plate full of chocolates, she would probably steal one or two, eat them, and then lie about it if asked. She added that she paid taxes, worked 40 hours a week, and thought of herself more as chubby than as a thief or a liar. The parents laughed in recognition of a common human failing. She then asked the parents what

Table 1

Adaptation of the MRI Model for Difficult Clients

- Discuss the solution first to avoid the denial and loss of face that accompany admitting wrongdoing. Many clients will refuse to find fault with their past behavior but will discuss constructively a plan for an improved future. This plan should be clear, specific, and sufficiently detailed to correct the problematic behavior. Once progress has been made, clients may more readily discuss the problem now outgrown with the benefit of hindsight.
- Add a developmental boost so clients, now "unstuck, "are directed toward a healthy path of growth and development.
- Facilitate ties to the community so clients have a network of resources when therapy ends.

they liked about their child, and, happily, they had much to say. They agreed that by focusing on the negatives they had almost forgotten the child's strengths.

Thus, the conversation shifted to a plan for the future that would focus on the child's strengths and lead him away from his problematic behaviors. The parents agreed that no physical force would be used in disciplining the boy and no loose change would be left around the house. The boy was paid $20 per month by the manager of the apartment complex for doing odd jobs. The parents, who had been cashing the check for him, decided instead to take the child to the bank to open his own account so he could deposit his checks. The parents agreed with the counselor's suggestion to call ahead and request that the person in charge of new accounts address the child as "Mister," put him on mailing lists, and promote earning interest by leaving money in the account. The parents smiled at the thought of how pleased the child would be to be treated like an adult depositing his paycheck. Furthermore, the parents agreed that if they asked him to run an errand they would expect him to use his own money and then present his receipt to be reimbursed. Tipping was to be allowed for a job especially well done, because this was part of the family's language. Both the reimbursement and the child's weekly allowance were to be paid by check. As a result, the only cash around the house would be the child's money. The parents were enthusiastic about this new approach and also were aware that it would be easy to backslide. Thus, they readily agreed to a few more meetings to reinforce the progress made during the initial interview.

BENEFITS:

The MRI model is useful in counseling difficult clients for the following reasons:

- **Brevity** (difficult clients cannot tolerate long-term work, are wary of ongoing relationships, or deal with too many problems to make more than only a few sessions practical);
- **Focus on behaviors that can be observed**;
- **Respect for the values and strengths of clients and firm commitment not to argue with them**;
- **Emphasis on small and tangible steps** that both improve the problem of the moment and potentially introduce the beginning of profound and lasting change.

By focusing first on the solution, instead of a definition of the problem, therapists can work with difficult clients without evoking their resistance or defensiveness about their past conduct; they can plan the immediate future in specific detail once the problem has been outgrown. Such respectful and collaborative work allows therapists to make suggestions, propose new approaches, and assist clients in building a network for future support.

Consolidating Gains

A number of verbal techniques can be used to strengthen the gains made during therapy (Watzlawick, 1978; Weakland & Jordan, 1990). The positive reframing developed throughout the session can be thematically connected with the new, planned behavior. **Rather than describing specifically what the new behavior should be (thereby infantilizing clients), the therapist can offer an anecdote, analogy, or vignette as a prompt and let the client volunteer an example for his or her situation** (Haley, 1973). In addition, the therapist can further strengthen the client's commitment to this prospective solution by replying, "Yes, but..." to the proposal. This deliberate, covert arguing not only gives clients an opportunity to work the bugs out of the new plans, but also fortifies their determination.

At this juncture, **the therapist should forewarn the client that minor setbacks and slips—normal parts of the learning process—*will* occur**. Occasional stumbles are part and parcel of learning by trial and error. By recognizing that occasional backsliding is inevitable, clients can then be assisted to develop nonpunitive ways to regroup rather than impulsively deem the new approach a failure and return to familiar but problematic ways.

Because it is difficult to listen well when under stress, clients may not accurately retain the information contained in the session or be clear afterward about what they really must do differently in the future. Putting new plans in writing with clients clarifying the steps to be taken, makes following through easier, and allows clients to document their efforts to any supervising system (the courts, probation, parole, etc.) when necessary. This need not be a cumbersome task nor result in a formal document: simply use a sheet of carbon paper to make two copies of what the client agrees to do. Both the therapist and the client sign and date the list, and both keep a copy. Typically, clients appreciate the clarity the agreement brings to the situation. Moreover, clients can craft the agreement in their own language, with therapists providing little more than secretarial support (except when clients reach an impasse or propose something impractical). **Clients are more likely to follow their own agreement than someone else's directive on how to lead their lives.**

A follow-up letter can serve the same function as an agreement drafted during the session. Even in such a format, **clients should be given as much credit for the solution as possible**. Therefore, the letter should describe and summarize their proposal. It can also contain referrals and information on services available in the community that clients might find helpful. Indeed, for diffident and perhaps tongue-tied clients, the letter can serve as a means of introduction to the new resource or provider of service.

A family of six had lived in one room in a motel for several years. The parents had been together for 15 years but argued frequently. A referral was made to Child Protective Services when a liquor bottle thrown by the mother at the father accidentally hit one of the children on the forehead, creating a large bruise and lump. The parents said they would never deliberately hurt their children; the father added that they were not stupid people and knew better than to argue in the presence of their children. He said if they lived in a two-bedroom apartment, they would not have a problem; however, with all of them living in one room, there was no place to go. He stated energetically that their privacy was important; thus, they could not go outside to argue because the neighbors would know their business. As their solution, they proposed that they would no longer argue.

The counselor replied that however well intended, this solution seemed unrealistic. She offered to provide some suggestions on obtaining financial assistance so they could move to larger quarters, although obtaining funding would take some time to accomplish. Therefore, she asked their indulgence with her next question: "Does this place have a laundry room?" After a shared chuckle, the parents agreed that they would argue in the laundry room and put a quarter in the dryer to muffle the sound for especially charged debates. The mother remarked that by the time they got all the way around to the other end of the building, they might not even feel like arguing. Although this is a positive statement by the mother, it is important not to agree too readily; agreement would reestablish the therapist's authoritative position and dampen the client's motivation to change. Therefore, the therapist remarked that if it was really important, they would, with effort, be able to resume the argument; if not, they could always save the quarter for the next time.

The agreement, which was signed by the parents, the school principal, and the counselor, read as follows:

> A and B understand that their family was referred to Child Protective Services out of concern for the safety of their children. The agency recognizes the love and commitment of the parents for their children, as well as the considerable efforts the parents make with limited means to provide adequate food, clothing, shelter, and supervision for the children. The parents agree that because the family lives in a one-room apartment, any fighting between the parents constitutes a potential threat

to the safety of the children. Therefore, in an effort to ensure the children's safety, A and B agree to:

1. Contact Catholic Social Services about housing subsidies so the family might move to a larger apartment (the address and phone number of the agency were written here);
2. Conduct adult disputes in the laundry room;
3. Attend weekly family counseling sessions for 3 months, beginning by the end of this month (three referrals are given here).

Building a Network of Support

Because difficult clients tend to be difficult people, they usually have few friends or sources of support. Moreover, they may have exhausted and burned bridges with more stable relatives, leaving them isolated and without the skills necessary to establish positive and supportive social ties or connections with programs in their community. In addition, because the involvement with a therapist is limited in duration and intimacy, a crucial part of any treatment plan should include assisting clients to establish ties with others.

Often, the problems of difficult clients dominate their days and nights; few have hobbies, interests, or relationships free of the stress, antagonism, or high drama of their lives. **Encouraging clients to take up a hobby or pursue an interest can yield benefits in a number of ways**:

1. It may provide the **necessary developmental boost** to propel them beyond their problems and toward rewarding growth
2. It may **develop social and applied skills in a normative (i.e., nonclinical) setting**
3. It may help them form a more **positive view of themselves**
4. It may lead to **friendships based on a shared, productive interest**
5. It may result in a **lasting source of enrichment** in an otherwise difficult life

Therapists should prepare themselves to serve as "reality coaches" while their clients make these initial forays into the outside world. **Difficult clients rarely are aware of how, and to what extent, they contribute to contentious exchanges.** Therapists often will need to provide constructive feedback about how to approach others, become part of a group, and initiate a friendship while clients attempt to become more connected with others. This is a key ingredient to a successful outcome because it **challenges the isolation so common among difficult clients. Therapy should not be terminated until clients have made at least one or two positive (and appropriate) attachments and have an awareness of the skills involved in forming such ties.**

Conclusion

The brief strategic approach to resolving problems lends itself well to clinical work with difficult clients: it focuses on tangible behaviors, builds on strengths, avoids antagonizing and arguing with volatile clients, and normalizes behavior that might otherwise contribute to the isolation common among difficult clients. The intention of this lesson is neither to suggest that the work is easy, nor that the clients will become pleasant and appreciative of the clinician's effort. Rather, the intent is to explore the challenges of working with especially troubled clients and to offer a few practical suggestions to make the work a bit easier.

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QUESTIONS BASED ON THIS LESSON

45. Which of the following statements is true?

A. Although brief therapy appreciates the strengths of difficult clients, it does not draw on their values.

B. It is reasonable for therapists to expect a difficult client to trust them readily.

C. In using a brief strategic approach to counseling, mental health professionals should recommend major changes—not slight ones—to facilitate lasting change.

D. Initial resistance on the part of the client should be viewed as a positive sign of strength and personal boundaries.

46. When clients complain about failed prior therapy:

A. The therapist should allow them to state their objections endlessly

B. They are demonstrating their lack of emotional control

C. The therapist should gauge the amount of responsibility taken by clients in contributing to the failed therapy

D. The therapist should automatically discredit the previous therapist in order to defuse clients' anger

47. Steps for avoiding arguments with difficult clients include all but which of the following:

A. Approving of anything clients say that sounds positive

B. Listening attentively to productive comments made by clients and always ignoring provocative ones

C. Framing advice in terms that are consonant with the clients' own language

D. Agreeing with clients as much as possible, even if the agreement must be qualified

48. Which of the following statements is false?

A. Contrary to popular belief, difficult clients are more likely to follow someone else's directive on how to lead their lives than their own agreement.

B. If clients do not readily respond to the opinion of their therapist, repeated presentation of this view—no matter how justified by reason—constitutes arguing.

C. One of the primary benefits of the MRI model is its brevity.

D. In solidifying gains made in therapy, therapists are advised to forewarn clients that minor setbacks will inevitably occur.

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